



Imagined in Policy, Inscribed on Bodies: Defending an Ethic of Compassion in a Political Context

Comment on “Why and How Is Compassion Necessary to Provide Good Quality Healthcare?”

Dave Mercer*

Abstract

In response to the *International Journal of Health Policy and Management (IJHPM)* editorial, this commentary adds to the debate about ethical dimensions of compassionate care in UK service provision. It acknowledges the importance of the original paper, and attempts to explore some of the issues that are raised in the context of nursing practice, research and education. It is argued that each of these fields of the profession are enacted in an escalating culture of corporatism, be that National Health Service (NHS) or university campus, and global neoliberalism. Post-structuralist ideas, notably those of Foucault, are borrowed to interrogate healthcare as discursive practice and disciplinary knowledge; where an understanding of the ways in which power and language operate is prominent. Historical and contemporary evidence of institutional and ideological degradation of sections of humanity, a ‘history of the present,’ serve as reminders of the import, and fragility, of ethical codes.

Keywords: Compassion, Ethics, Nursing, Health Politics, Neoliberalism, Austerity, Human Rights

Copyright: © 2015 by Kerman University of Medical Sciences

Citation: Mercer D. Imagined in policy, inscribed on bodies: Defending an ethic of compassion in a political context: Comment on “Why and how is compassion necessary to provide good quality healthcare?” *Int J Health Policy Manag.* 2015;4(10):681–683. doi:10.15171/ijhpm.2015.125

Article History:

Received: 30 May 2015

Accepted: 8 July 2015

ePublished: 10 July 2015

*Correspondence to:

Dave Mercer

Email: dmercer@liverpool.ac.uk

Introduction

This short commentary is an invited response to Marianna Fotaki’s editorial ‘*Why and how is compassion necessary to provide good quality healthcare?*’ published in the *International Journal of Health Policy and Management*.¹ It is a timely and valuable contribution to current debates about compassionate care in the context of specific failures in National Health Service (NHS) provision, and mediated reports of diminished public confidence in healthcare more generally. The title poses 2 key questions facing those individuals who, respectively, shape health policy, deliver caring services, or have responsibility for the preparation and training of future practitioners; and to each of these issues, ‘compassion’ and ‘ethical awareness’ are central constructs. Though, as it is noted, they are too often conflated and confused in both intellectual and ‘common sense’ accounts of the constituents of high-quality care; obfuscating individual attributes and organisational cultures.

In this reply, key themes from the paper are explored in relation to nursing academe, focusing on education and research which, it has long been argued, represent the foundations of progressive practice. Discussion is framed by an acknowledgement of the Foucauldian concept of ‘discursive practice,’ as a way of understanding the historic and cultural rules that produce different forms of knowledge, and permit certain statements to be made.² Translated into social research, this set of perspectives is represented by the contribution of discourse analysis as a form of inquiry that

prioritises the ‘discursive construction of reality.’³ Here, attention is given to the performative, and collective, function of language in shaping the world around us, where what we ‘know,’ or accept as ‘truth,’ are inextricably linked to power and ideology.^{4,6} These interrelated themes are elaborated below in terms of healthcare politics, research, practice, and education (wrapped up tidily in university ‘corporate speak’ as ‘knowledge exchange’).

Politics and Research

In the United Kingdom, healthcare is a political issue. The NHS is the last vestige of traditional socialist ideals of welfare founded on the principle of ‘free to all, at the point of need.’⁷ As an institution, its values are so deeply embedded in the public psyche that no ‘serious’ political party could campaign on an election manifesto that did not offer to protect the spirit of universality. Or, so it is routinely argued. Yet, results of the May 2015 election across England, Scotland, and Wales tell a different story, where any sense of collectivism was demolished by a surge of nationalism. The Scottish Nationalist Party (SNP) may have purveyed an ‘anti-austerity’ message to the voters and Westminster but, generally, identity prevailed over common interest. The reelection of a Government, freed of any coalition control, which systematically dismantled public services,⁸ is a harbinger of the ideological landscape upon which future debate about healthcare ethics, and practice, will take place.

Activists, academics, and health economists note the

detrimental effect, on health inequalities, of unchecked neoliberalism,^{9,10} as a global movement that, in short, celebrates market forces as the basis of political liberty. A scholarly review of how global financial crisis impacts on physical and mental health¹¹ is summarised, more succinctly, as ‘austerity kills.’¹² In the UK context, healthcare reforms – as a euphemism for privatisation – are coupled to further attacks on civil liberties with government proposals to abolish the *Human Rights Act* in favour of a *British Bill of Rights*; another example of de-universalisation as discursive practice in neoliberal times, where the ethical foundations of freedom and dignity are progressively chipped away.

Nurses, typically, work with vulnerable and marginalised groups, framed by a statutory duty of ‘care’ and ‘candour,’ to ‘treat people with kindness, respect and compassion’¹³; a laudable, and paramount, set of principles that stand proudly against the pro-genocidal discourse of tabloid reporting around immigration, asylum seekers, and refugees.¹⁴ The rise of the Nazi Party in pre-war Germany, though, is a dark reminder of how easily dominant nationalist ideologies can hijack intellectual and liberal aspirations, with import for how ethics are taught on nursing programmes today.¹⁵ Like all healthcare professionals, nursing research is guided by ethical principles enshrined in the Declaration of Helsinki (2000) that echo the Nuremberg Code (1947); a response to ‘human experimentation,’ and state sanctioned murder, in the death camps of the Third Reich.

The history of the Holocaust illustrates the extent to which doctors and nurses were willing to actively collude in bureaucratised killing of adults and children, in their care, with mental illness or a learning disability^{16–18}; actions defended as ‘medical therapy,’ with individual ethics abandoned for the greater good of the ‘fatherland.’ The chief lesson to be learned is not rooted in the character traits of fascist street thugs or tyrannical sadists. Rather, it centres on the appropriation of psychiatric *knowledge* expressed in the spurious *science* of eugenics, within an ideological discourse that legitimated ‘mercy killing,’ without mercy¹⁹; deviance inscribed on the body of the ‘other.’ Such a ‘history of the present’²⁰ raises profound and troubling questions for contemporary practitioners in the context of an increasingly visible, pan European, right-wing political presence.^{21,22}

Practice and Education

Given the past failure of ethics, discussed above, the nursing profession needs to define itself as a ‘moral community,’ coalesced around the ethics of witness and virtue.¹⁵ Two major UK inquiry reports, into high-secure care, published in the 1990s^{23,24} produced finding that characterised the worst excesses of the old asylum system, and led to major structural and legislative changes. They described an insular and oppressive world, with an institutional culture described as racist, sexist, and densely macho. More recent research findings suggest that little has changed since that time, despite massive capital investment and culture-change programmes.^{25,26} This raises questions for how ethical protection, and compassionate care, can be safeguarded for those groups who are vulnerable, excluded and marked by the stigma of a spoiled identity. Unlike current examples of a collapsed ‘duty to care,’²⁷ related to general service provision for the seriously ill and elderly,

prisoners and mentally disordered offenders do not make for the same sympathetic media coverage.

The idea of an ‘ethics of testimony’ as being important for nursing philosophy and science is also central to the work of Georges²⁸ who sees self-reflection as one way of challenging Eurocentric reductionism, and reconceptualising the concept of ‘suffering.’ It is suggested that increased attention to structural inequalities like sexism and racism should replace dominant cultural narratives which equate problems with ‘pathology,’ and solutions in terms of ‘therapy.’ Similarly, Ben-Sefer²⁹ argues that it is knowledge of ‘suffering’ rather than ‘history’ that needs incorporating into the design of nursing curricula as a way of combating intolerance and hate crime. The involvement of ‘prisoner nurses’ detained in concentration camps, it is posited, reframes ethical theorising about ‘choice,’ and situates personal decision-making in the context of politics and power relations.³⁰ It is suggested that masculinist discourses of ‘disconnection’ constructed a bio-political space in which moral categories collapsed, and corporeal violence was inscribed on the flesh of the inmate. The disciplinary knowledge of psychiatry, and discursive practice of mental health nurses, is riven with ethical dilemmas from involuntary detention under mental health legislation to ‘treatment’ methods³¹; described as a ‘web of power’ where tablets and talk can be equally invasive.³² Critical scholars suggest that: “Psychiatry is not a mere medical science: it is an intensely political system of interrelated practices, discourses, and institutions.”³³ In such settings, the enactment of concepts like ‘advocacy’ and ‘therapeutic engagement’ are permeated by what is referred to as the ‘capillary power’ of the carceral system, or micro-physics of disciplinary regimes.³⁴ For mental health nurses in general, and forensic staff in particular, any ethical framework is compromised, or constrained, by a dual allegiance to the person (care) and the state (control).

More generally, national and international evidence suggests that organisational cultures exert an impact on care and compassion in relation to, both, qualified members of staff and nurses in training.^{35,36} Typically, this is described as damaging and detrimental to the philosophy of the profession, and quality markers of health policy; a ‘hidden curriculum’ where ‘learning on the job’ in clinical settings incrementally erodes levels of empathy.³⁷ Central to Fotaki’s paper,¹ is a real concern about how compassion is cultivated, and embedded, in practice, and her discussion offers a valuable summary of philosophical and pragmatic issues in relation to a recent case study of care failures.²⁷ Against this background, the author of the present paper, with a colleague, was commissioned by NHS North West to undertake a ‘values and behaviours’ evidence review.³⁸ The findings, and themes, were congruent with the work of Fotaki.

Concluding Remarks

Professor Fotaki has furnished an excellent editorial relating to a very real concern in UK healthcare, which deserves a wide readership for all those concerned with ensuring that compassion and care remain at the heart of service provision.¹ It artfully integrates ethical debate with real world strategies, but it is for the individual reader to interpret these in the context of their own role and responsibilities. This is what has been attempted in this response. None of the content

has been challenged, or alternative views expressed. As an academic nurse, with a long career in high-secure care, it was an interesting opportunity to rethink these issues in the context of an organisational culture that personally shaped an ongoing intellectual critique of ethics and politics in forensic psychiatry. I would like to thank the editorial team at *IJHPM* for inviting me to write this paper, and hope that it complements the original.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

DM is the single author of the manuscript.

References

1. Fotaki M. Why and how is compassion necessary to provide good quality healthcare? *Int J Health Policy Manag.* 2015;4(4):199-201. doi:10.15171/ijhpm.2015.66
2. O'Farrell C. *Michel Foucault*. London: Sage; 2005.
3. Cameron D. *Working with Spoken Discourse*. London: Sage; 2001.
4. Fairclough N. *Language and Power*. 2nd ed. London: Longman; 2001.
5. Wood LA, Kroger RO. *doing Discourse Analysis: Methods for Studying Action in Talk and Text*. London, Sage; 2000.
6. Potter J, Wetherell M. *Discourse and Social Psychology: Beyond Attitudes and Behaviour*. London: Sage; 1987.
7. Delamothe T. NHS at 60: Founding principles. *BMJ.* 2008;336(7655):1216-1218. doi:10.1136/bmj.39582.501192.94
8. Pollock AM, Price D. The final frontier: The UK's new coalition government turns the English National Health Service over to the global health care market. *Health Soc Rev.* 2011;20(3):294-305. doi:10.5172/hesr.2011.20.3.294
9. De Vogli R. Neoliberal globalisation and health in a time of economic crisis. *Soc Theory Health.* 2011;9(4):311-325. doi:10.1057/sth.2011.16
10. Player S, Pollock AM. Long-term care: From public responsibility to private good. *Crit Soc Policy.* 2001;21(2):231-255. doi:10.1177/026101830102100204
11. Stuckler D, Basu S. *The Body Economic: Eight Experiments in Economic Recovery, From Iceland to Greece*. London: Penguin; 2014.
12. Stuckler D. *The Body Economic: Why Austerity Kills*. Presented as Eleanor Rathbone Public Lecture Series; 15 April, 2015; Department of Sociology, Social Policy and Criminology, School of Law and Social Justice.
13. Nursing and Midwifery Council (NMC). *The code: Professional Standards of Practice and Behaviour for Nurses and Midwives*. London: NMC; 2015:4.
14. Webber F. One nation: But whose? <http://www.irr.org.uk/news/one-nation-but-whose/>. Accessed May 22, 2015. Published May 20, 2015.
15. McKie A. 'The demolition of man': Lessons from the holocaust literature for the teaching of nursing ethics. *Nurs Ethics.* 2004;11:138-149. doi:10.1191/0969733004ne679oa
16. Benedict S, Caplan A, Lafrenz Page T. Duty and 'euthanasia': The nurses of Meseritz-Obrawalde. *Nurs Ethics.* 2007;14:781-794. doi:10.1177/0969733007082118
17. Seeman MV. Psychiatry in the Nazi era. *Canadian Journal of Psychiatry.* 2005;50:208-224.
18. Friedlander H. Registering the handicapped in Nazi Germany: a case study. *Jewish History.* 1997;11:89-98. doi:10.1007/bf02335679
19. Michalsen A, Reinhart K. 'Euthanasia': a confusing term, abused under the Nazi regime and misused in present end-of-life debate. *Intensive Care Med.* 2006;32(9):1304-1310. doi:10.1007/s00134-006-0256-9
20. Garland D. What is a 'history of the present'? On Foucault's genealogies and their critical preconditions. *Punishment and Society.* 2014;16(4):365-384. doi:10.1177/1462474514541711
21. McKeown M, Mercer D. Mental health care and resistance to fascism. *J Psychiatr Ment Health Nurs.* 2010;17:152-161. doi:10.1111/j.1365-2850.2009.01489.x
22. Benedict S, Kuhla J. Nurses' participation in the euthanasia programs of Nazi Germany. *West J Nurs Res.* 1999;21(2):246-263. doi:10.1177/01939459922043749
23. Blom-Cooper L, Brown M, Dolan R, Murphy E. *Report of the Committee of Inquiry into Complaints about Ashworth Hospital*. London: HMSO; 1992.
24. Fallon P, Bluglass R, Edwards B, Daniels G. *Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital*. London: HMSO; 1999.
25. Mercer D, Perkins E. Theorising sexual media and sexual violence in a forensic setting: Men's talk about pornography and offending. *Int J Law Psychiatry.* 2014;37(2):174-182. doi:10.1016/j.ijlp.2013.11.003
26. Mercer D. Girly mags and girly jobs: Pornography and gendered inequality in forensic practice. *Int J Ment Health Nurs.* 2013;22(1):15-23. doi:10.1111/j.1447-0349.2012.00837.x
27. Department of Health (DOH). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (The Francis Report)*. London, Stationery Office; 2013.
28. Georges JM. The politics of suffering: Implications for nursing science. *Adv Nurs Sci.* 2004;27:250-256. doi:10.1097/00012272-200410000-00002
29. Ben-Sefer E. Lessons from the past for contemporary Australian nursing students: the Nazi Euthanasia program. *Nurse Educ Pract.* 2006;6:31-39. doi:10.1016/j.nepr.2005.06.002
30. Georges JM. An ethics of testimony: Prisoner nurses at Auschwitz. *Adv Nurs Sci.* 2006;29:161-169. doi:10.1097/00012272-200604000-00009
31. Holmes D, Rudge T, Perron A, eds. *(Re)Thinking Violence in Health Settings: A Critical Approach*. Surrey: Ashgate; 2012.
32. Holmes D, Jacob JD, Perron A, eds. *Power and the Psychiatric Apparatus: Repression, Transformation and Assistance*. Surrey: Ashgate; 2014.
33. Jacob JD, Perron A, Holmes D. Introduction: unmasking the psychiatric apparatus. In: Holmes D, Jacob JD, Perron A, eds. *Power and the Psychiatric Apparatus: Repression, Transformation and Assistance*. Surrey: Ashgate; 2014:1.
34. Foucault M. *Discipline and Punish: The Birth of the Prison*. New York: Vintage Books; 1977.
35. Baillie L, Gallagher A. Respecting dignity in care in diverse care settings: strategies of UK nurses. *Int J Nurs Pract.* 2001;17(4):336-341. doi:10.1111/j.1440-172x.2011.01944.x
36. Spandler H, Stickley T. No hope without compassion: The importance of compassion in recovery-focused mental health services. *J Ment Health.* 2011;20(6):555-566. doi:10.3109/09638237.2011.583949
37. Baillie L, Ford P, Gallagher A, Wainright P. Nurses' views on dignity in care. *Nurs Older People.* 2009;21(8):22-29.
38. Flynn M, Mercer D. Is compassion possible in a market-led NHS? *Nurs Times.* 2013;109(7):12-14.